You can fill out this form on-line.

Print Clear Form

REQUEST FOR LEAVE OR APPROVED ABSENCE

1. NAME *(Last, First, Middle Initial)*	2. EMPLOYEE ~~SOCIAL SECURITY NUMBER~~ BADGE NO.

3. ORGANIZATION

4. TYPE OF LEAVE/ABSENCE *(Check appropriate box(es) below.)*	DATE From:	DATE To:	TIME From:	TIME To:	TOTAL HOURS
☐ Accrued Annual Leave					
☐ Restored Annual Leave					
☐ Advance Annual Leave					
☐ Accrued Sick Leave					
☐ Advance Sick Leave					
Purpose: ☐ Medical/dental/optical examination of requesting ☐ Other ☐ Care of family member/bereavement, including medical/dental/optical examination of family member					
☐ Compensatory Time Off					
☐ Other Paid Absence *(Specify in Remarks)*					
☐ Leave Without Pay					

5. FAMILY AND MEDICAL LEAVE

If annual leave, sick leave, or leave without pay will be used under the Family and Medical Leave Act of 1993, please provide the following information:

☐ **I hereby invoke my entitlement to Family and Medical Leave for:**

- ☐ Birth/Adoption/Foster Care
- ☐ Serious Health Condition of Spouse, Son, Daughter, or Parent
- ☐ Serious Health Condition of Self

Contact your supervisor and/or your personnel office to obtain additional information about your entitlements and responsibilities under the Family and Medical Leave Act of 1993.

6. REMARKS:

7. CERTIFICATION: I hereby request leave/approved absence from duty as indicated above and certify that such leave/absence is requested for the purpose(s) indicated. I understand that I must comply with my employing agency's procedures for requesting leave/approved absence (and provide additional documentation, including medical certification, if required), and that falsification of information on this form may be grounds for disciplinary action, including removal.

EMPLOYEE SIGNATURE **DATE**

8. OFFICIAL ACTION ON REQUEST: ☐ **APPROVED** ☐ **DISAPPROVED**

(If disapproved, give reason. If annual leave, initiate action to reschedule.)

SIGNATURE **DATE**

PRIVACY ACT STATEMENT

Section 6311 of title 5, United States Code, authorizes collection of this information. The primary use of this information is by management and your payroll office to approve and record your use of leave. Additional disclosures of the information may be: To the Department of Labor when processing a claim for compensation regarding a job connected injury or illness; to a State unemployment compensation office regarding a claim; to Federal Life Insurance or Health Benefits carriers regarding a claim; to a Federal, State, or local law enforcement agency when your agency becomes aware of a violation or possible violation of civil or criminal law; to a Federal agency when conducting an investigation for employment or security reasons; to the Office of Personnel Management or the General Accounting Office when the information is required for evaluation of leave administration; or to the General Services Administration in connection with its responsibilities for records management.

Where the employee identification number is your Social Security Number, collection of this information is authorized by Executive Order 9397. Furnishing the information on this form, including your Social Security Number, is voluntary, but failure to do so may result in disapproval of this request.

If your agency uses the information furnished on this form for purposes other than those indicated above, it may provide you with an additional statement reflecting these purposes.

EMPLOYEE—Check the appropriate box below (Items 1-4) if you are applying for sick leave. If your agency requires such certification, please have your doctor or practitioner complete the Certification section below. Falsification of information in this portion of the form may be grounds for disciplinary action, including dismissal.

1. I was incapacitated for duty by:

- ☐ **Sickness.**
- ☐ **Off-The-Job Injury.**
- ☐ **On-The-Job Injury.**
- ☐ **Pregnancy and Confinement.**

2. I was required to care for a member of my family with a contagious disease. *(Give name and relationship of family member, and name of disease.)*

☐

3. I will be undergoing medical, dental, or optical examination or treatment.

☐

4. I was exposed to a contagious disease. *(Give name of disease and circumstances of exposure.)*

☐

CERTIFICATION OF PHYSICIAN OR PRACTITIONER

Employee's Name	**Period Under Professional Care** *(Indicate Month, Day, Year)*	
	From:	**To:**

Remarks

I certify that the employee named was under my professional care for the period indicated above, and that the employee's condition during this period made reporting to work inadvisable.

Signature of Physician or Practitioner	**Date** *(Month, Day, Year)*